

Integrated HRA Enrollment Form – City of Cincinnati Employees

EMPLOYER INFORMATION

Employer Name: **City of Cincinnati**

Please send completed enrollment forms and information to:

City of Cincinnati Risk Management - 805 Central Avenue, Suite 100 - Cincinnati, OH 45202

Fax: 513.352.3761 / Email: Phyliss.Ward@Cincinnati-oh.gov

For Questions Call: 877-872-4232 or email CinciHRA@JandKcons.com

I am enrolling in the Integrated HRA for: _____ Single _____ Family

PARTICIPANT INFORMATION

Employee Name:		Birthdate:	Hire Date:
Social Security No:	Employee ID No.:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date Eligible for HRA:
Home Street Address:			
City:		State:	Zip Code:
Home Phone:		Work Phone:	Cell Phone:
Email Address:		Fire, Police or Union Affiliation:	

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security No:	Spouse's Employer:	
Spouse's Pay Period for Health Premium Contribution: <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Weekly		
Spouse's Health Premium Contribution Pay Period: _____ ** INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT		
Are Spouse's Health Premium Contribution / Deductions: <input type="checkbox"/> Before Taxes (OR) <input type="checkbox"/> After Taxes		

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.
If submitting a spousal paystub, please circle the contribution/deduction amount on the submitted paystub. DO NOT BLACKOUT THE PAY PERIOD.
** Send a copy of your spouse's paystub that shows the NEW contribution/deduction amount for the effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan. *Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may be only once a month or the first two pays of each month.*
* If your spouse's plan has a High Deductible with an HSA, Health Savings Account, you are not eligible to participate in the Integrated HRA, unless the spouse's employer allows your spouse to drop the HSA portion of the plan. **If your primary health insurance coverage is through Medicare, Tricare, or any City of Cincinnati sponsored health plan you are not eligible for the Integrated HRA.**

*****You must provide proof of dependent eligibility i.e. marriage certificate, birth certificate, etc.*****

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize the City of Cincinnati to enroll me into the employer sponsored Integrated HRA. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. I further understand that if any current contributions are made to an HDHP/HSA, I am not eligible to participate in the Integrated HRA offered through the City of Cincinnati.

Employee Signature:

Date: